

# REQUEST FOR SICK LEAVE FOR VETERAN WITH SERVICE RELATED DISABILITY

## Notice of Statutory Provisions: M.S. 43A.184

Pursuant to M.S. 43A.184, a state employee who is a veteran with a service related disability may apply to the employee's appointing authority for additional sick leave to receive treatment for the disability. The employee must qualify as a veteran under M.S. 197.447, and have a sick leave balance that is insufficient to receive treatment for the disability. The appointing authority may authorize up to an additional 40 hours of sick leave for the employee in the current fiscal year. The appointing authority may approve sick leave for an employee under these provisions one time in each fiscal year. Should the absence be FMLA qualifying, the 40 additional hours will be applied to the FMLA time limits.

This form must be submitted to the agency Human Resource Office.

## SECTION I (to be completed by the Employee)

Employee Name: \_\_\_\_\_ Employee I.D. Number: \_\_\_\_\_

Employee's Agency: \_\_\_\_\_ Employee's Supervisor: \_\_\_\_\_

Number of Sick Leave Hours Being Requested: \_\_\_\_\_ Current Sick Leave Balance: \_\_\_\_\_

## SECTION II – Certification of Service Related Disability

A copy of a Department of Veterans Affairs disability rating letter (or military service disability rating letter) verifying the employee's service related disability must be provided.

## SECTION III – Certification of Treatment

The attached Certification of Treatment form must be completed and submitted to the Human Resources Office.

## SECTION IV (to be completed by the Agency)

Request for additional sick leave: Is approved ☐ Is **not** approved ☐

\_\_\_\_\_  
Signature of Agency Designee

\_\_\_\_\_  
Date

***If approved, follow these instructions to process the addition of sick leave hours to the employee's sick leave bank:***

In Mass Time Entry, Current Period Adjustment or Prior Period Adjustment, enter earn code \*SL and the number of hours to be added to the employee's sick leave balance.

## CERTIFICATION OF TREATMENT FORM

*The Certification of Treatment form must accompany all requests for additional sick leave pursuant to M.S. 43A.184, (additional sick leave for veterans with a service related disability).*

### SECTION I (to be completed by the Employer)

Employee name: \_\_\_\_\_ Employee ID# \_\_\_\_\_

Employee's job title: \_\_\_\_\_ Regular Work Schedule: \_\_\_\_\_

Employee's essential job functions OR position description is attached ☐

### SECTION II (to be completed by the Employee's Health Care Provider)

1. Health Care Provider's Name and Business Address:

\_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_ Email: \_\_\_\_\_

2. Is the patient being treated for a military service related disability? Yes ☐ No ☐

Approximate date condition commenced: \_\_\_\_\_

Probable duration of the condition and/or need for care: \_\_\_\_\_

Dates or time period you have treated the patient for condition: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the list of the employee's essential functions or a job description is not included, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: Yes ☐ No ☐

If so, identify the job functions the employee is unable to perform:

For what period of time will the employee be unable to perform the job functions (either totally or partially)?

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave.

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_